

**TESTIMONY OF
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REHABILITATION
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BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON
VETERANS' AFFAIRS**

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Good afternoon Mr. Chairman and Members of the Committee.

I am Dr. Barbara Sigford and I serve as VA's National Program Director for Physical Medicine and Rehabilitation. Joining me this morning is Dr. Lucille Beck, VA's Chief Consultant for Rehabilitation Services.

Thank you for this opportunity to talk about the Veterans Health Administration's (VHA) seamless transition process from the perspective of the Polytrauma System of Care. Mr. Chairman, recent reports of difficulties faced by service members and veterans in receiving the care they need and deserve have been deeply troubling. We at the VA are working closely with DoD to do everything we can to address and resolve problems in the delivery of care.

Polytrauma System of Care

The mission of the Polytrauma System of Care is to provide the highest quality of medical, rehabilitation, and support services for veterans and active duty service members injured in the service to our country. This is a system of care consisting of four regional Polytrauma Rehabilitation Centers (PRC), which provide acute intensive medical and rehabilitation care for complex and severe polytraumatic injuries; 21 Polytrauma Rehabilitation Network Sites (PNS), which manage post-acute sequelae of polytrauma; and 76 Polytrauma Support Clinic Teams (PSCT) located at local medical centers throughout the 21 Networks, which serve patients with stable polytrauma sequelae. This system of care has been designed to balance the needs of our combat injured for highly specialized care with their needs for local access to life long rehabilitation care.

The four PRCs are located in Minneapolis, MN; Palo Alto, CA; Richmond, VA; and Tampa, FL. They have built on the experience of the Traumatic Brain Injury (TBI) Lead Centers that had functioned at these locations for 15 years. The PRCs serve as hubs for acute medical and rehabilitation care, research, and education related to polytrauma and TBI. They provide overall exemplary care for veterans with multiple injuries including brain injuries. Due to the increasing needs for transitional and community re-entry services, each PRC is currently developing a transitional community re-entry program that will be operational in July, 2007. Palo Alto already has such a program in place.

The PNSs, which are located one in each of VHA's 21 Veterans Integrated Service Networks (VISN), provide key components of specialty rehabilitation care that address the ongoing specialty needs of individuals with polytrauma, including, but not limited to inpatient and outpatient rehabilitation, day programs, and transitional rehabilitation. PNSs are responsible for coordinating access to VA and non-VA services across the VISN to meet the needs of patients and families with polytrauma.

Due to their wider geographical distribution, PSCTs play an important role in improving access to local rehabilitation services for veterans and active duty service members closer to their home communities. These teams are responsible for managing patients with stable treatment plans, providing regular follow-up visits and responding to new problems as they emerge. They provide consult with their affiliated PNS or PRC when more specialized services are required.

Facilities in the Polytrauma System of Care are linked through a Telehealth Network that provides state-of-the-art multipoint videoconferencing capabilities. The Polytrauma Telehealth Network (PTN) ensures that polytrauma and TBI expertise are available throughout the system of care and that care is provided at a location and time that is most accessible to the patient. Clinical activities performed using the PTN include remote consultations, evaluations, treatment and education for providers and families.

Case management is a critical function in the Polytrauma System of Care, designed to ensure lifelong coordination of services for patients with polytrauma and TBI. Every patient seen in one of the polytrauma programs is assigned a case manager who maintains scheduled contacts with veterans and their families to coordinate services and to address emerging needs. As an individual moves from one level of care to another, the case manager at the referring facility is responsible for a "warm hand off" of care to the case manager at the receiving facility closer to the veteran's home. The assigned case manager functions as the Point of Contact for emerging medical, psychosocial, or rehabilitation problems, and provides patient and family advocacy.

Transition from DoD to VA

Severely injured veterans and service members and their families make transitions unknown in the civilian sector. They must make transitions across space, time and systems. The Polytrauma System of care has developed consistent and comprehensive procedures to ensure seamless transition of the combat injured from the Military Treatment Facilities (MTFs) to the PRCs. Several processes have been put in place to make it possible to transition patients from DoD to VA care at the appropriate time and under optimal conditions of safety and convenience for the patients their families. These processes address three key elements: continuity of medical care, psychosocial

support for patients and families, and logistical supports such as transportation and housing.

Transition of Medical Care

The PRCs receive advanced notice of potential admissions to their sites through standardized mechanisms. After notification, the PRC team initiates a pre-transfer review and follows the clinical progress until the patient is ready for transfer. PRC clinicians are able to complete pre-transfer review of the MTF electronic medical record via remote access capability. Up to date information about medications, laboratory studies, results of imaging studies and daily progress notes are available. They are also able to access additional clinical information through the web-based Joint Patient Tracking Application (JPTA) where information from the field notes from Balad, Iraq and follow up at Landstuhl, Germany are available and indispensable in determining the severity of the TBI. In addition to record review, clinician-to-clinician communication occurs to allow additional transfer of information and resolution of any outstanding questions. VA has stationed a Certified Rehabilitation Registered Nurse (CRRN) at Walter Reed Army Medical Center to constantly monitor the clinical status of patients awaiting transfer to a PRC. She is available to the PRC staff for up-to-date information. Also, VA social workers are stationed at 10 MTFs to assist with necessary transmission of clinical information. PRCs also have scheduled video teleconferences (VTC) with the MTFs to discuss the referral with the transferring team and to meet the patient and family members “face to face” whenever feasible.

Psychosocial Support for Transition

Families of injured service members are stressed and require particular assistance in making the transition from the acute medical, life and death, setting of an MTF to a rehabilitation setting. This support encompasses psychological support, education about rehabilitation and the next setting of care, and information about benefits and military processes and procedures. VA social workers are located at 10 MTFs, including our most frequent referral sources, Walter Reed Army Medical Center and National Naval Medical Center. These individuals provide necessary psychosocial support to families during the transition process. They advise the families and “talk them through” the process. In addition, the CRRN provides education to the family on TBI, the rehabilitation process, and the PRCs. The Admission Case Manager from the PRC is in personal contact with the family prior to transfer to provide additional support and further information about the expected care plan. VA also has Benefit liaisons located at the commonly referring MTFs to provide an early briefing on the full array of VA services and benefits to the patients and families.

Upon admission to the PRC, the senior leadership of the facility personally meets and greets the family and service member to ensure that they feel welcome and

that their needs are being met. Additionally, a uniformed active duty service member is located at each PRC. The Army Liaison Officers support military personnel and their families from all Service branches by addressing a broad array of issues, such as travel, non-medical attendant orders which pay for family members to stay at the bedside, housing, military pay, and movement of household goods. They are also able to advise on Medical Boards and assist with necessary paperwork.

Two of the four PRCs (Minneapolis and Palo Alto) have Fisher Houses to lodge visiting family members. The Tampa VA Fisher House is scheduled for completion in April 2007, and ground-breaking for the Richmond Fisher House is planned for this spring.

Logistical Supports for the Transition Process

The third element in a smooth transition is attention to logistical supports. Through the coordination of the PPRC social workers and the Voluntary Services Department, the individual needs of the family are assessed and attended to. Supports provided include transportation, housing, access to meals, and when needed specialized equipment such as car seats, cribs, etc. Even child care can be arranged. In addition, each PRC has added special activities for the families to make their stay more relaxing.

Over arching all these efforts, is the addition of a new OIF/OEF Program Manager to oversee coordination of the care and services provided to all OIF/OEF veterans seen at the facility, and to assure that severely-injured/ill OIF/OEF veterans are case managed by a social worker or nurse case manager. This individual will work closely with the existing clinicians and PRC nurse and social work case managers, adding an additional layer of security and coordination.

Transition from the Polytrauma Rehabilitation Center to the Community

The transition from the PRC to the home community is also of critical importance. The needs at time of transition remain the same: medical care, psychosocial support, and logistical. Records for medical care are readily available through remote access across the VA system. In addition, the transferring practitioners are readily available for personal contact with the receiving provider to ensure full and complete communication. Follow up appointments are made prior to discharge. For psychosocial support, the proactive case management system provides for ongoing support and problem solving in the home community while continually assessing for new and emerging problems. Finally, in terms of logistical support, each PRC team carefully assesses the expected needs at

discharge for transportation, equipment, home modifications, and other such needs and makes arrangements for assessed needs.

Conclusion:

Finally, I would like to again recognize that the VA is committed to providing the highest quality of services to the men and women who have served our country. It is important to note that last week the President created an Interagency Task Force on Returning Global War on Terror Heroes (Heroes Task Force), chaired by the Secretary of Veterans Affairs, to respond to the immediate needs of returning Global War on Terror service members. The Heroes Task Force will work to identify and resolve any gaps in service for service members. As Secretary Nicholson said, no task is more important to VA than ensuring our heroes receive the best possible care and services. The VHA's work to provide a seamless transition process for high quality medical, rehabilitation, and support services for veterans and active duty service members injured in the service of our nation is helping to ensure that our heroes do receive the best possible care.

Mr. Chairman, this concludes my statement. At this time I would be pleased to answer any questions that you may have.